SUMMARY OF BENEFITS Connecticut General Life Insurance Co.

Wilson County Government
Open Access Plus Plan

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited per individual	
Pre-Existing Condition Limitation (PCL)	Applies; Waived up to age 19 yrs old	Applies; Waived up to age 19 yrs old
Coinsurance	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met

Maximum Reimbursable Charge
• Determined based on the lesser of:
  • the health care professional's normal charge for a similar service; or
  • a percentage of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area.
• In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is determined based on the lesser of:
  • the health care professional's normal charge for a similar service or supply; or
  • the amount charged for that service by 80% of the health care professionals in the geographic area where it is received.
• Out-of-network services are subject to a calendar year plan deductible and maximum reimbursable charge limitations.
	N/A	110%

Calendar year plan deductible • The amount you pay for any expenses counts towards both your in-network and out-of-network plan deductibles. (Cross accumulation). • After each family member meets his or her individual plan deductible, the plan will pay his or her claims, less any coinsurance amount. After the family plan deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.	**Employee** **(Based on Yrs of Service)** New hire thru 4 yrs: $600 5 yrs thru 9 yrs: $500 10 yrs thru 14 yrs: $400 15 yrs+: $300 **Employee and Family** $1,800	**Employee** $1,800 **Employee and Family** $5,400
Calendar year out-of-pocket maximum • The amount you pay for any services counts towards both your in-network and out-of-network out-of-pocket maximums. (Cross accumulation) • Plan deductibles contribute towards your out-of-pocket maximum. • Copays do not contribute towards your out-of-pocket maximum	**Employee** $1,800 **Employee and Family** $3,600	**Employee** $5,400 **Employee and Family** $10,800

Annual deductibles and maximums	In-network	Out-of-network
• Mental health and substance abuse services contribute towards your out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. After the family out-of-pocket maximum has been met, the plan will pay 100% of each individual's covered expenses.		

Benefits	In-network	Out-of-network
Physician services		
Office visit • Primary care physician and specialist office visits	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Physician services (hospital) • In hospital visits and consultations • Inpatient services • Outpatient services	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Surgery (in a physician's office)	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Preventive care		
Preventive care • Includes well-baby, well-child, well-woman and adult preventive care • Includes immunizations • Includes lab and x-ray billed by the doctor's office	100%; No charge, no plan deductible	Not covered
Mammogram, PSA, Pap Smear and Maternity Screening • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	100%; No charge, no plan deductible	You pay 40% Plan pays 60% after the plan deductible is met
Inpatient hospital facility services		
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc.	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met

Benefits	In-network	Out-of-network
Inpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Multiple surgical reduction • Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	Included	Included
Outpatient services		
Outpatient surgery (facility charges) • Non-surgical treatment procedures are not subject to the facility copay/benefit deductible.	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Outpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Physical, occupational, cognitive and speech therapy • Limited to 90 days per calendar year for all therapies combined • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Cardiac rehabilitation • Limited to 36 days per calendar year	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Chiropractic services • Limited to 20 days per calendar year	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Lab and X-ray		
Lab • Physician's office • Outpatient hospital facility • Independent lab facility	100%; No charge, no plan deductible	You pay 40% Plan pays 60% after the plan deductible is met
X-ray • Physician's office • Outpatient hospital facility • Independent x-ray facility	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met

Benefits	In-network	Out-of-network
Lab and X-ray, emergency room and urgent care • Emergency room when billed by the facility as part of the emergency room visit • Urgent care when billed by the facility as part of the urgent care visit. • Independent x-ray and/or lab facility in conjunction with a emergency room visit	You pay 20% Plan pays 80% after the plan deductible is met	
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Physician's office visit • Outpatient facility • Inpatient hospital facility	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Emergency room • Urgent care facility	You pay 20% Plan pays 80% after the in-network plan deductible is met	
Emergency and urgent care services		
Hospital emergency room • Includes radiology, pathology and physician charges • Out-of-network services are covered at the in-network rate.	You pay a per visit co-pay of $300, plus You pay 20% Plan pays 80% after the in-network plan deductible is met (co-pay is waived, if admitted)	
Ambulance • Out-of-network services are covered the same as in-network services. Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered.	You pay 20% Plan pays 80% after the in-network plan deductible is met	
Urgent care services • Out-of-network services are covered at the in-network rate.	You pay 20% Plan pays 80% after the in-network plan deductible is met	
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities • 100 days maximum per calendar year combined for all facilities listed	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Home health care • 30 days maximum per calendar year; 16 hour maximum per day	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Hospice • Inpatient services • Outpatient services	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met

Benefits	In-network	Out-of-network
Other health care services		
Durable medical equipment • Unlimited calendar year maximum	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
External prosthetic appliances (EPA) • Unlimited calendar year maximum	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
TMJ **Surgical & Non-surgical case by case basis subject to medical necessity. Always excludes appliances & orthodontic treatment.** • Doctor's Office • Inpatient Facility • Outpatient Facility • Physician's Services	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed.
Maternity Care Services • Covers maternity for employee and spouse. Only complications of pregnancy are covered for dependent children.	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Infertility treatment	Not Covered	Not Covered
Family planning • Inpatient hospital facility • Outpatient facility • Physician services • Surgical services such as tubal ligation or vasectomy are covered (excluding reversals). • Includes contraceptive devices	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Mental health and substance abuse services		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: • Substance Abuse includes Alcohol and Drug Abuse services. • Transition of Care benefits are provided for a 90-day time period.		
Inpatient mental health services • Unlimited days per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum.	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Outpatient mental health physician's office services • Unlimited visits per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual, group therapy mental health and intensive outpatient mental health	You pay 20% Plan pays 80% after the medical plan deductible is met	You pay 40% Plan pays 60% after the medical plan deductible is met

Benefits	In-network	Out-of-network
Outpatient mental health facility services • Unlimited visits per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual, group therapy mental health, and intensive outpatient mental health	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Inpatient substance abuse services • Unlimited days per calendar year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum.	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Outpatient substance abuse physician's office services • Unlimited visits per calendar year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual and intensive outpatient substance abuse	You pay 20% Plan pays 80% after the medical plan deductible is met	You pay 40% Plan pays 60% after the medical plan deductible is met
Outpatient substance abuse facility services • Unlimited visits per calendar year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual and intensive outpatient substance abuse	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Prescription Drugs		
Cigna Pharmacy three-tier copay/coinsurance plan • No mandatory generics • Self administered injectable and optional injectable drugs – excludes infertility drugs • Includes Oral Contraceptives • Prescription smoking cessation drugs included • Prescription vitamins included • Insulin pens and cartridges included	**Retail** (30 day supply) You pay: Generic $4 Preferred Brand 20% Non-Preferred Brand 30% **Home Delivery** (90 day supply) You pay: Preventive Generic $0* Generic $4 Preferred Brand 20% Non-Preferred Brand 30% ***Please refer to listing of Preventive Generics.**	Not Covered
Pharmacy calendar year out-of-pocket maximum • Applies to retail and home delivery pharmacy co-pays apply to out-of-pocket maximum per calendar year • Applies to in-network	**Individual** $1,500 **Family** $3,000	
Pharmacy Clinical Management and Prior Authorization • Your plan is subject to certain clinical edits and prior authorization requirements.		

Benefits	In-network	Out-of-network
Step Therapy • Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered. • All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.		
Clinical Outcome Programs • Includes complex psychiatric case management • Includes narcotic therapy management		

Specialty Pharmacy
• Clinical Programs
  ○ Prior authorization required on specialty medications and quantity limits may apply.
  ○ TheraCare® Program
• Medication Access Option: Retail and/or Home Delivery		

Routine Vision Care	Not covered under medical plan	

Definitions

Coinsurance – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Co-pay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Direct Access to Obstetricians and Gynecologists – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Out-of-pocket Maximum – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Pre-existing condition limitation – Not applicable to anyone under 19 years old. Applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details.

Prescription Drug List – The list of prescription brand and generic drugs covered by your pharmacy plan.

Selection of a Primary Care Provider – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Transition of Care – Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Maximizing your health care dollars

Log on to myCigna.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, Cigna offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Cigna Home Delivery Pharmacy –You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. Cigna's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker's Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Infertility Services
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Acupuncture
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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Additional Information

Additional Benefit Information	In-network	Out-of-network
Prescription Drug List: • Cigna Standard Prescription Drug List •		
Pharmacy Clinical Management and Prior Authorization • Refill-too-soon and plan exclusion edits are always included. • Additional clinical management – **Basic package** – provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications..		
Pharmacy Cost Management Program (Step Therapy) High Blood Pressure (ACEI/ARB) • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included Cholesterol Lowering (STATIN) • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included Heartburn/Ulcer (PPI) • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included • **Nexium is Excluded under the Pharmacy Benefits.** Bladder Problems (OAB) • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included Osteoporosis (BONE) • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included Sleep Disorders (HYPNOTICS) • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included Allergy (NASAL STEROIDS) • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to		

Additional Benefit Information	In-network	Out-of-network
using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included <u>Depression (SSRI/SNRI)</u> • *Generic or PB First One Step* – Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication. • 60 days grace period • First Fill Pay and Educate included		
Pre-admission certification – continued stay review (PHS)	Coordinated by provider/PCP	Employee is responsible for contacting Cigna Healthcare. A 50% penalty is applied to hospital inpatient charges for failure to contact Cigna Healthcare to pre-certify admission. Benefits are denied for any admission reviewed by Cigna Healthcare and not certified. Benefits are denied for any additional days not certified by Cigna Healthcare.
Case Management	Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.	
Mental health/Substance abuse utilization review, case management and programs	Capitation (CAP) - Inpatient and Outpatient Management • Case Management and Utilization Review for Inpatient Services (In-Network, Out of Network) and Outpatient Services (In-Network only) Provided by Cigna Behavioral Health (CBH). • Includes Lifestyle Management Programs: Stress management & Tobacco Cessation, Healthy Steps to Weight Loss.)	
MH/SA Service Specific Administration	The following administration applies for Partial Hospitalization, Residential Treatment, and Intensive Outpatient Programs: • *Partial Hospitalization and Residential Treatment:* Covered as inpatient Mental Health and/or Substance Abuse. • *Intensive Outpatient Program (IOP):* Covered as outpatient Mental Health and/or Substance Abuse	

Additional Benefit Information	In-network	Out-of-network
Annual Reinstatement	Not Included	
Allergy treatment/injections	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Allergy serum (dispensed by the physician in the office)	You pay 20% Plan pays 80% after the plan deductible is met	You pay 40% Plan pays 60% after the plan deductible is met
Bereavement counseling - inpatient services	Paid the same as Inpatient Hospice Facility	Paid the same as Inpatient Hospice Facility
Bereavement counseling – outpatient services	Paid the same as outpatient Hospice Facility	Paid the same as outpatient Hospice Facility
Abortion • Provides non-elective coverage	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Organ Transplant • Inpatient 100% at Lifesource center after plan's $0 inpatient per admission copay, otherwise same as plan's inpatient hospital facility benefit • Physician services: Covered at 100% at Lifesource center; otherwise 80% after plan deductible • Travel maximum $10,000 per transplant (only available if using Lifesource facility)	Cost and reimbursement vary based on the facility in which it is performed	Not Covered
Dental Care • Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Obesity/bariatric surgery rider • Subject to medical necessity and clinical guidelines • $25,000 lifetime maximum. Only surgical services count towards maximum (charges for surgeon only; does not include radiologist, anesthesiologist, etc.) • The following are excluded: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • The following are excluded: weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Cost and reimbursement vary based on the facility in which it is performed	Not Covered
Routine Foot Disorders	Not Covered	Not Covered
Included Health and Wellness Programs		
eVisits	Not Included	

Additional Benefit Information	In-network	Out-of-network
Lifestyle Management Programs - included with Cigna Behavioral Advantage • Weight Management • Tobacco Cessation • Stress Management	Included	

Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Covered Services and Supplies."
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
- Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization,

Exclusions

gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

- Reversal of male and female voluntary sterilization procedures.
- Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or “Breast Reconstruction and Breast Prostheses” sections of "Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Covered Services and Supplies”.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies.”
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.

Exclusions

- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
- Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations and telemedicine.
- Massage Therapy

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.